Mental Illness: Primer on definitions

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Disclosures

- View and opinions do not necessarily reflect those of the State of Utah or University of Utah
- No conflicts of interest
- Any referenced research IRB approved; any patient info de-identified or public domain

Overview USH Forensic Unit

- Continuous accreditation by federal agencies
- Active original research and tracking outcomes
- “Difficult Patient Conference”
- Continuing Medical Education
- Training site: nursing, social work, psychology, psychiatry
- Maximum but “soft” security
- “Holistic” with focus on competency
- DSM 5 field trials
- Most patients non-violent, get better, resolve their case
- No evidence underdiagnose malingering (10% discharged patients)
- Conservative with release decisions
- Downstream of various systems limitations

Mental Illness: Relevance to Criminal Justice System

- Deinstitutionalization in 1950s → Trans-institutionalization today
- 2 Million with Serious Mental Illness (SMI) enter corrections annually in US; 25% of enrolled public care SMI have involvement in criminal justice system over 2 year period
- Double cost compared to SMI without criminal justice involvement; longer stays, higher rates recidivism, less access to health care, feedback loop (disruptive/aggressive behavior=more charges=longer jail/prison stays); most lost to follow-up within six months in community (National Assoc of Counties, CSF Summit 2015)
- About half SMI receive no treatment in correctional settings
- Often begin in childhood: relevant to juvenile justice system
- High rates of suicide in correctional settings
- Brown v. Plata, 131 S. Ct. 1910 (2011): improve healthcare or release prisoners
- Issues of follow-up care, adherence to treatment, risk/recidivism/community intolerance

State Mental Health Agency (SMHA), Per Capita Mental Health Services Expenditures

	FY2004	FY2005	FY2006	FY2007	FY2008
Location	SMHA Expenditures Per Capita	SMHA Expenditures Per Capita	SMHA Expenditures Per Capita	SMHA Expenditures Per Capita	SMHA Expenditures Per Capita
Mississippi	$95.50	$105.68	$110.07	$121.12	$109.40
Pennsylvania	$186.46	$204.92	$208.51	$259.65	$273.01
Utah	$73.56	$64.34	$58.29	$64.93	$65.27

What is a Mental Illness?

Defies simple, reductionist explanations; often no precise cut point from “normal” functioning

Mental disorder is predicate condition for legal issues: Civil commitment, Incompetence, Guilty and Mentally Ill, NGRI

Statutory definitions: broad and allow discretion, vary from state to state in clarity and specificity

- **UCA 76-2-305**

  “Mental illness" means a mental disease or defect **that substantially impairs** a person's mental, emotional, or behavioral functioning. A mental defect may be a congenital condition, the result of injury, or a residual effect of a physical or mental disease and includes, but is not limited to, mental retardation. Mental illness does not mean an abnormality manifested primarily by repeated criminal conduct

- **UCA 62A-15-102**

  Severe mental disorder" means schizophrenia, major depression, bipolar disorders, delusional disorders, psychotic disorders, and other mental disorders as defined by the division

- **UCA 62A-15-602**

  "Mental illness" means a psychiatric disorder as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association **which substantially impairs** a person's mental, emotional, behavioral, or related functioning

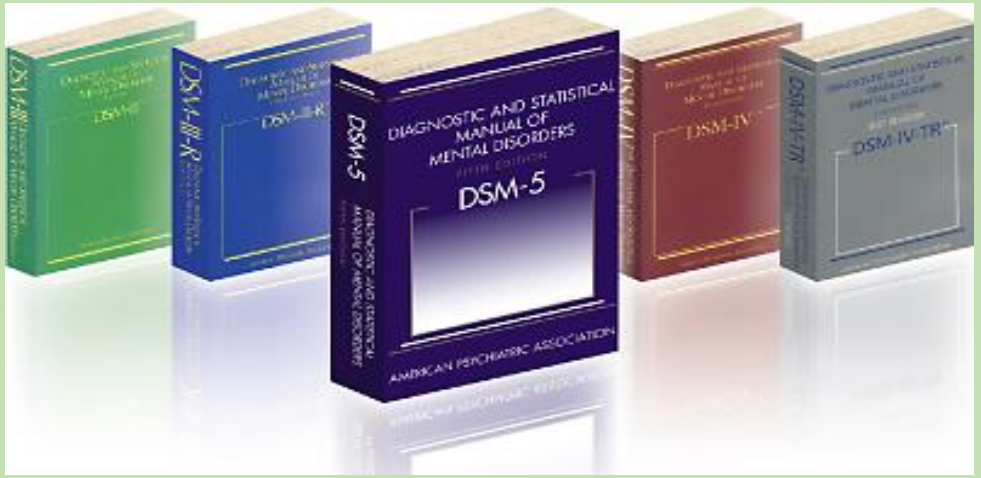
DSM V: Emphasis on causing significant disability (social, occupational) or distress

American Psychiatric Association Model Guidelines: “severe mental disorder” is a brain disorder… substantially impairing various spheres of functioning, associated with broad deterioration & severe disability

Not an expected or culturally sanctioned response to a stressor or loss, not socially deviant behavior (political, religious, sexual) or conflict between individual and society, unless the deviance/conflict is result of the mental disorder

Diagnostic and Statistical Manual (DSM)

- Manual used to diagnose mental conditions in US; updated 2014 (DSM-5)
- Categorically classifies disorders into types based on defining criteria w/exclusions
- 20 broad categories (e.g., Psychotic Disorders, Mood Disorders, Substance Abuse Disorders….)
- Atheoretical: does not invoke causes
- Caveats
- *Cautionary Statement*: Page 25
- Strengths: reliability, utility, evidence based
- Weaknesses: not fully validated but improving, consensus based
- Not a “Bible”



DSM, Continued: Organization

- **Category**, example: "Schizophrenia and other Psychotic Disorders"
- **Types**: (7) Schizophrenia, Schizophreniform, Schizoaffective, Delusional Disorder, Brief Psychotic Disorder, Psychotic Disorder due to General Medical Condition, Substance Induced Psychotic Disorder
- **Criteria:** various inclusionary & exclusionary
- Subtypes/Severity/Course

Example, Schizophrenia

Table 1. *DSM–IV* draft criteria for schizophrenia

A. Characteristic symptoms: At least two of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) delusions
(2) hallucinations
(3) disorganized speech (e.g., frequent derailment or incoherence)
(4) grossly disorganized or catatonic behavior
(5) negative symptoms, that is, affective flattening, alogia, or avolition

Note:—Only one A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thought, or two or more voices conversing with each other.

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms that meet criterion A (i.e., active phase symptoms), and may include prodromal and/or residual periods when the A criterion is not fully met. During these periods, signs of the disturbance may be manifested by negative symptoms or two or more symptoms listed in criterion A present in an attenuated form (e.g., blunted affect, unusual perceptual experiences).

D. Boundary with schizoaffective disorder: The disturbance is not better accounted for by schizoaffective disorder (i.e., to diagnose schizophrenia, symptoms meeting criteria for an episode of mood disorder should not be present for a substantial portion of the disturbance).

E. Boundary with mood disorder with psychotic features: The disturbance is not better accounted for by a mood disorder with psychotic features (i.e., to diagnosis mood disorder with psychotic features, delusions or hallucinations have not been present for more than 2 weeks in the absence of prominent mood symptoms, i.e., immediately before the mood symptoms developed or right after they remitted).

F. Substance/secondary exclusion: The disturbance is not due to a substance-induced or secondary psychotic disorder.

Multiaxial Diagnostic Formulation

- Axis I: Major Mental Illness: (Types) SCZ, Major Depression, Anxiety, Dementia, etc
- Axis II: Personality Disorders; Mental Retardation (Mild, Moderate, Severe)
- Axis III: Medical conditions that are relevant

New DSM is moving away from this conceptualization, however

What is psychosis?

- Not a diagnosis per se, indicates presence of psychotic symptoms
- No stock answer: inability to distinguish what is real from what is not; inability to test subjective ideas and experiences against objective facts of the world as most people would agree they are, typically with loss of insight and absence of a corrective mechanism
- Isolated symptoms common in non-clinical populations; must be expertly assessed and associated with significant impairment to be considered a symptom of mental illness
- Involve abnormalities in chemical messengers in brain (neurotransmitters)
- Can occur in many disorders: severe depression (e.g., infanticide), bipolar disorder, various medical problems, substance abuse (typically time-limited, other than methamphetamine)

Schizophrenia

1% worldwide population: Identical Twin = 50% risk

Unknown Cause: complex genetic risk + environmental stresses →

change in brain functional connectivity/biochemistry →

risk of psychotic symptoms

25% inpatient psychiatric hospital beds

Begins late adolescence; usually lifelong

4th leading cause disability 15-44

Large majority: Impaired, unemployed, difficulties functioning; often homeless

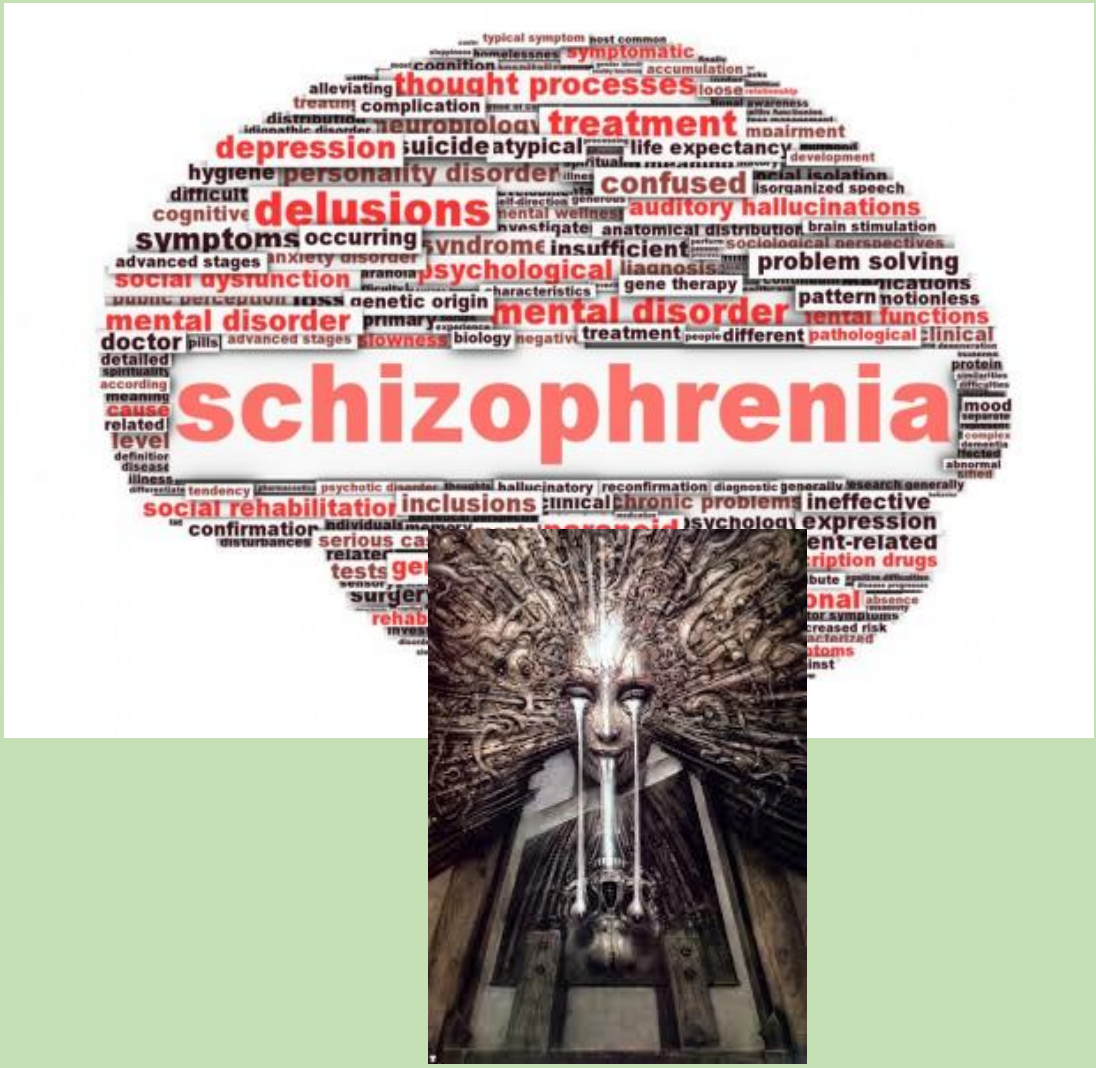
High rates of substance abuse: 50%, accounts for most risk of violence

Up to 20% never diagnosed

Diagnosis remains stable over time

“Modest” increased risk of violence (including homicide) over norms: New onset, persecutory delusions, anger. Treatment reduces risk (3x)

Schizophrenia Spectrum: SCZ, schizophreniform, delusional disorder, schizoaffective, etc



Schizophrenia Symptoms

- No one symptom is indicative
- Significant heterogeneity in presentation
- High comorbidity: depression, substance abuse
- Chronic methamphetamine-induced psychosis can be indistinguishable
- Positive psychotic symptoms: Delusions, hallucinations (unpleasant, external cause, commenting-insulting-commanding); referential beliefs (coincidences have personal meaning); thought broadcasting/withdrawal/implantation, etc
- Negative psychotic symptoms: Apathy, amotivation, social withdrawal, immediate reward gratification, reduced emotional expression
- Cognitive symptoms: Memory, attention, planning
- Disorganization: Speech nonsensical or inefficient, behavior, nonpurposeful bizarre
- Any of the above can affect competency-abilities

Delusion

- Relatively fixed, false belief based on incorrect inference about externality reality and firmly maintained despite (potential) evidence to contrary; unusual dominating effect on individual, persistent, impairing, distressing (to self or others), not subculturally sanctioned
- Universal themes: persecutory, grandiose, jealousy, somatic (body malfunction), mixed-types
- Content is typically product of times, often relate to individual's baseline interests or concerns
- Bizarre/non-bizarre
- Can be difficult to establish: No discrete threshold, value-laden decision; ways to minimize uncertainty
- Dimensions to increase accuracy: if non-bizarre, less "what" one believes than "how" they believe
  - Level of conviction
  - How preoccupying
  - Level of perspective
  - Behavioral extensions
  - Sharedness with subculture vs. idiosyncratic
  - Imperviousness to counter-argument
  - "centrality" of individual, poor "people skills" (metacognitive abilities, "reading other people" deficits)
  - Thinking errors: "jumping to conclusions", abnormal salience of neutral data

Delusional Disorder

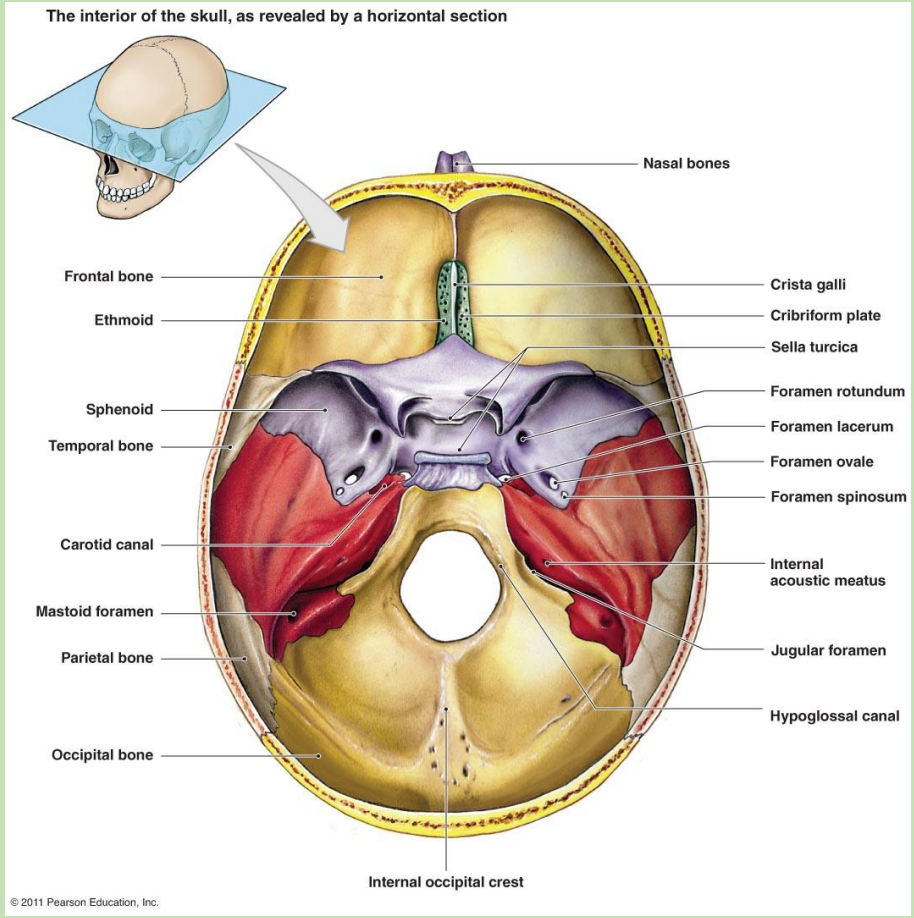
- Non-bizarre delusion (i.e., could occur in real life) without other major psychotic symptoms
- Apart from the impact of the delusion and ramifications, behavior not impaired or odd; “high functioning” individuals
- litigious/querulent, excessive religiosity, paranoid, grandiose (e.g., potential legal involvement: fraud, “prophets”, stalkers, assassins)
- No insight into their problems, typically refuse mental health interventions
- Rare: but 2000 along Wasatch Front
- Give legal, correctional, & mental health systems fits

Diagnosis in Forensic Settings

- Not beholden to court finding regarding mental illness
- Often a process, not an event
- Not meant to cast a spell of certitude
- Can change over time (typically not with schizophrenia)
- Bayesian reasoning
- Process: Serial clinical interviews, mental status exam, collateral information, exhaustive review of records, past history, labs/physical exam (many medical problems can have psychiatric presentations), family history, longitudinal observation
- Minimize uncertainty: Second opinions/case conference
- Professional Organizations have role in regulating expert testimony (i.e, Am. Academy of Psychiatry and the Law)

Traumatic Brain Injury (TBI)

- (see handout)
- 1% of US population; forensic context can be child abuse, spousal abuse (50%)
- Definition:
- Most mild, 20% moderate/severe
- Significant risk factors for psychiatric problems; causality problematic (association vs. cause)
- Frontal lobe/severe injury amplifies risks of aggression
- Violence characteristics: often impulsive, unplanned, little objective other than reactionary; poor awareness
- Relatively high rates of malingering in legal settings
- Management problems: limited role of medication, limited resources for aftercare and funding inadequacy
- Usually in isolation would not meet criteria for civil commitment, unless comorbid major psychiatric problem (may however, through *Division of Services for People with Disabilities*, http://www.hsdspd.utah.gov/)



Personality Disorder

- Definition: pattern inner experience/behavior deviates markedly from expectations…
- "Extreme" people: longstanding rigid, inflexible, and poor modulation of impulses, emotions, behavior, perceptions since adolescence; leads to dysfunction
- 12%-15% of US population estimated to have at least one (e.g., seem inordinately "unstable", or paranoid, or odd, or narcissistic, over broad range situations)
- "Stress" can push over into psychosis, typically briefly
- 10 different ones, several relevant to forensic issues
- Unclear if "long term hospitalization" helps
- High co-occurence with Axis I, however (e.g., 70% of Borderline PD are diagnosed with mood, anxiety, or substance abuse problems)
- Difficult to make in presence of untreated Axis I, such as Schizophrenia
- Debatable whether in isolation would meet definition of mental illness, however see *Kansas v. Crane* 543 US 407, 122 (2002) & progeny
- Examples…

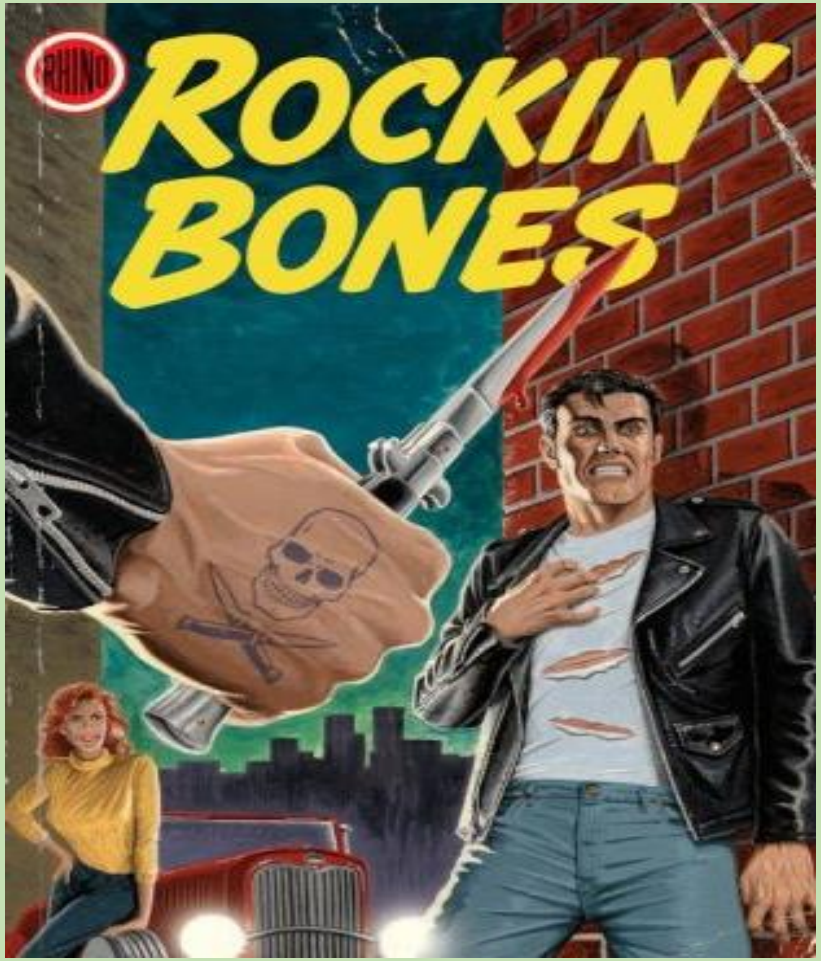
Paranoid Personality Disorder

- Longstanding inflexible worldview: distrust and suspicious, people are out to exploit me, bears grudges, rigid, watchful, easily feel violated or mistreated, don't tolerate ambiguity well; humorless and intense
- Often high functioning, not "psychotic" per se such as having hallucinations or specific systematized delusional belief
- Example:

Borderline Personality Disorder

- Pervasively unstable in terms of relationships, emotions, impulsive (sex, spending, substance abuse, reckless driving); recurrent “suicidal” behavior or deliberate self-harm (cutting to relieve stress), fear abandonment or closeness, rage
- Reactive to sense of rejection, abandonment: domestic abuse, substance abuse, potential violence

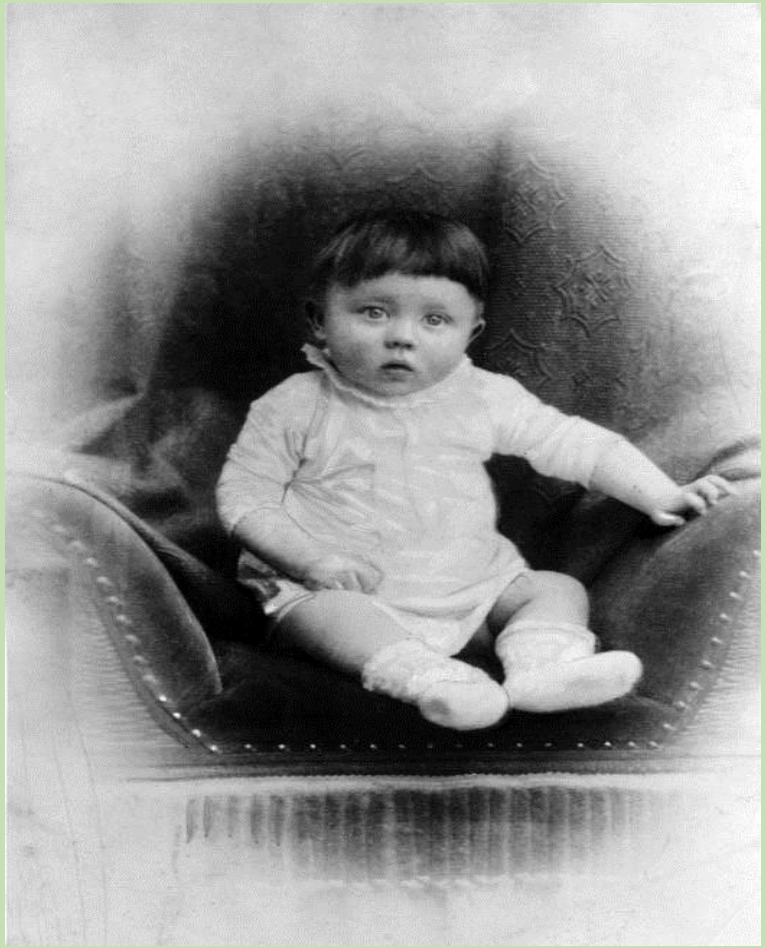
Antisocial Personality Disorder



- “Oldest” personality disorder (since DSM1)
- Pervasive pattern of disregard for and violation of rights of others At least 18 years old
- Not equal to generic criminal behavior, “for gain” crimes
- Evidence of conduct disorder prior to age 15
- Not exclusively during course of other major mental illness
- Estimates 20-40% correctional population
- ?if early intervention helps (childhood)
- Relation to “psychopathy”….

Psychopathy

- Subset of Antisocial PD, account for disproportionate amounts of violence
- Cleckley 1941, Hare (PCL-R) measurement tool; not a DSM Diagnosis
- Problems with use in legal settings:
- Behaviors, interpersonal deficits, emotional dysregulation
- Most will meet diagnosis of antisocial PD, but not vice-versa
- Most not violent (but risk factor); not psychotic
- Can be highly successful, not necessarily criminals
- Intimidation, impulsive, egregious, cold blooded behavior
- 20% of serial violent schizophrenia patients with have significant psychopathy traits



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